KAISER PERMANENTE®

California Small Group
EMPLOYER APPLICATION

To ensure timely processing, complete each section of this application in its entirety.

Requested effective date ____ / 01 / ____

1 ABOUT BUSINESS

Legal business name	Doing business as (DBA)

Physical address **(no P.O. boxes)**	City	State	ZIP	County

Phone ( ) –	Business website

Type of business ☐ Corporation ☐ Sole proprietorship ☐ Partnership ☐ LLC ☐ Other:

In business since (mm/dd/yyyy) / /	Federal Tax ID or EIN	NAICS 6-digit code (visit **naics.com/search**)

Employers must have workers' compensation coverage and cover all employees, unless exempt or not required by law. I attest that the following information is correct.

☐ Yes, my company has workers' compensation. ☐ Pending

If *Yes* or *Pending*, name of carrier: _____ Policy # _____
(indicate *unknown* or *pending* as applicable)

☐ Exempt from providing workers' compensation for the following reason: _____

2 OTHER MEDICAL COVERAGE

Does your company or affiliated company(ies) have or ever had group coverage directly through Kaiser Permanente? If *Yes*, please provide the group number and company name.

☐ Yes ☐ No Group #: Company name:

Does your company currently have active group health coverage?

☐ Yes ☐ No Name of carrier: Renewal month:

Will you be offering another carrier's small group health plan coverage, alongside Kaiser Permanente, to your employees?

☐ Yes ☐ No Name of carrier: **Number of employees enrolled with other carrier:**

3A EMPLOYER ELIGIBILITY

In determining the number of employees or eligible employees, affiliated companies eligible to file a combined tax return for purposes of state taxation shall be considered 1 employer.

Is your company affiliated with another company and eligible to file a combined tax return? ☐ Yes ☐ No

If *Yes,* please provide below:

Company name _____ ☐ Affiliate ☐ Subsidiary

Address	City	State	ZIP

Federal Tax ID or EIN	Phone ( ) –

Business name (please print): _____

3B EMPLOYEE COUNT

Please provide the total number of employees nationwide **(full and part-time).**

Total _____ **If the total number of employees is 100 or fewer, skip the following and go to section 3C.**

If your total number of employees noted above is more than 100, please provide the total number of **full-time and full-time-equivalent employees** on the line below. To qualify for small group coverage, your company must have at least 1 but no more than 100 full-time and full-time equivalent employees for at least 50% of the previous calendar quarter or previous calendar year. For information on calculating the number of full-time and full-time-equivalent employees (FTE), refer to your legal counsel.

Total _____

3C ELIGIBLE AND ENROLLING EMPLOYEES

Please provide the total number of **eligible employees.** Total _____

Please provide the total number of **enrolling employees.** Total _____

Hours per week employees must work to be eligible for coverage: ☐ minimum 20 hours ☐ minimum 30 hours

Are you offering dependent coverage? ☐ Yes ☐ No

If you have 50 or more full-time or full-time-equivalent employees, you must offer dependent coverage. See section 4980H(C)(2) of the Internal Revenue Code about Employer Shared Responsibility.

3D DOMESTIC PARTNER COVERAGE

Are you offering non-state registered Domestic Partner Coverage? ☐ Yes ☐ No

4 CONTINUATION COVERAGE

Did your company employ 20 or more employees for at least 50% of the workdays of the preceding calendar year (January through December), making it subject to COBRA? ☐ Yes ☐ No

Are you submitting COBRA applications? ☐ Yes ☐ No

5A ERISA STATUS

Is your company subject to ERISA? ☐ Yes ☐ No If left unmarked, this will default to *Yes.*

ERISA sets minimum federal standards for employee benefit plans established by private employers and employee organizations. Refer to ERISA | U.S. Department of Labor (dol.gov) or consult with your financial or legal advisor.

5B MEDICARE SECONDARY PAYOR STATUS

Are you subject to TEFRA? ☐ Yes ☐ No

Your group is subject to this federal law if your company employed 20 or more full-time and/or part-time employees for each working day for 20 or more calendar weeks in the current calendar year or preceding calendar year.

6 EMPLOYER PREMIUM CONTRIBUTION

Your contribution to coverage can be a percentage or a fixed dollar amount. **Your minimum contribution must be at least 50% of the "employee only" monthly premium for the lowest-priced Kaiser Permanente medical plan offered by you, the employer.**

Percentage of the premium is based on the following **(select 1 only):**
☐ Lowest plan offered ☐ All plans offered ☐ Specific plan offered: _____

Employer contribution (50%–100%): _____ % per employee _____ % per dependent **(optional)**
Employer contribution (fixed $): $ _____ per employee $ _____ per dependent **(optional)**

Business name (please print): _____

7A CONTRACT AND RENEWAL DELIVERY PREFERENCE

We'll deliver your Kaiser Foundation Health Plan, Inc. (KFHP)/Kaiser Permanente Insurance Company (KPIC) contract(s)/renewal(s) online in a PDF file at account.kp.org unless you indicate that you would like your contract(s)/renewal(s) mailed to you.

If you want to receive your contract(s) by mail, call Kaiser Permanente's Membership Administration team at **800-731-4661.**

☐ Check this box if you want to receive your renewal(s) by mail.

7B CONTRACT SIGNER

The contract signer is authorized to make membership or contractual changes and is responsible for receiving and providing renewal information to your account. This address will become the group mailing address, if different from the business physical address.

First name	MI	Last name	Title

Mailing address	City	State	ZIP

Office phone ( ) –	Ext.	Cell phone ( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

7C BILLING CONTACT

The **billing contact** is the one person within your company to whom billing statements are addressed and will have access to group information. **If you're using a Third-Party Administrator (TPA), including a broker acting as a TPA for billing administration, please skip the following and proceed to section 7D.**

☐ **Check here if same as contract signer.**

First name	MI	Last name

Billing address	City	State	ZIP

Office phone ( ) –	Ext.	Cell phone ( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

Business name (please print): _____

7D THIRD-PARTY ADMINISTRATOR (TPA) CONTACT

The **TPA** is an organization or broker contracted to have access to your group's information and provide operational services including employee benefits management, billing, enrollment, and administering **Federal COBRA** benefits. **Note:** A TPA can't administer state Cal-COBRA.

TPA company name

Will the TPA administer Federal COBRA? ☐ Yes ☐ No ☐ Check here if COBRA statement will be sent to group's billing address.

First name	MI	Last name

Mailing address	City	State	ZIP

Office phone	Ext.	Cell phone
( ) –		( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

7E INTERESTED PARTY CONTACT (OPTIONAL)

An **interested party** is not a broker but an individual, within your organization, authorized to discuss and receive group specific information and make contract changes.

First name	MI	Last name

☐ Check here if using the same address as the Contract Signer in section 7B.

Mailing address	City	State	ZIP

Office phone	Ext.	Cell phone
( ) –		( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

ADDITIONAL INTERESTED PARTY

First name	MI	Last name

☐ Check here if using the same address as the Contract Signer in section 7B.

Mailing address	City	State	ZIP

Office phone	Ext.	Cell phone
( ) –		( ) –

Email	How should we correspond with this person? **(select 1 only)** ☐ Email ☐ Mail

Business name (please print): _____

8A MEDICAL PLANS

Select the plan(s) you'd like to offer. For more information on the plans listed below, contact your sales representative, agent/broker, or visit our website at kp.org/smallbusinessplans/ca.

- Groups with 1 to 5 enrolled subscribers can offer a choice of up to 4 HMO Kaiser Permanente plans, plus 1 PPO plan for a maximum of 5 plans.
- Groups with 6 or more enrolled subscribers can offer a choice of 1 or more HMO Kaiser Permanente plans, plus 2 PPO plans.
- PPOs can only be offered when Kaiser Permanente is the sole carrier.

Platinum	☐ Platinum 90 HMO 0/10 PCP + Child Dental Alt†	☐ Platinum 90 PPO 0/15 PCP + Child Dental
	☐ Platinum 90 HMO 0/20 PCP + Child Dental	
	☐ Platinum 90 HMO 250/30 PCP + Child Dental Alt†	
Gold	☐ Gold 80 HMO 0/35 PCP + Child Dental Alt†	☐ Gold 80 PPO 350/25 PCP + Child Dental
	☐ Gold 80 HMO 250/35 PCP + Child Dental	
	☐ Gold 80 HMO 1000/40 PCP + Child Dental Alt†	
	☐ Gold 80 HDHP HMO 1750/15% PCP + Child Dental Alt	
	☐ Gold 80 HRA HMO 2250/35 PCP + Child Dental	
Silver	☐ Silver 70 HMO 1900/65 PCP + Child Dental Alt†	☐ Silver 70 PPO 2500/55 PCP + Child Dental
	☐ Silver 70 HMO 2300/65 PCP + Child Dental Alt†	
	☐ Silver 70 HMO 2500/55 PCP + Child Dental	
	☐ Silver 70 HMO 2900/65 PCP + Child Dental Alt†	
	☐ Silver 70 HDHP HMO 2850/25% PCP + Child Dental	
Bronze	☐ Bronze 60 HMO 5800/60 PCP + Child Dental	☐ Bronze 60 PPO 5800/60 PCP + Child Dental
	☐ Bronze 60 HDHP HMO 6650/0 PCP + Child Dental	

Child Dental: We're required to include child dental benefits with your medical plan(s). When employees and their dependents enroll in the HMO medical plan(s) you've chosen, we'll also enroll them in a separate child dental plan underwritten by Delta Dental of California. PPO medical plan members receive child dental benefits as part of their medical coverage and not as a separate plan. Child dental services apply to all members under 19 years old.

†Chiropractic and acupuncture benefits are included with these plans.

Groups selecting the Gold 80 HRA HMO 2250/35 PCP plan must fund an HRA for each enrolled employee. The allowable funding range is $200 to $400 per employee and $400 to $800 per family.

HDHP plans are HSA-qualified. Kaiser Permanente can administer your HSA or HRA health payment account. Select *Yes,* and a Kaiser Permanente representative will contact you to provide more information on your next steps, as additional documents and administrative fees apply.

HSA administered through Kaiser Permanente? ☐ **Yes** ☐ **No** **HRA administered through Kaiser Permanente?** ☐ **Yes** ☐ **No**

8B FERTILITY BENEFIT (OPTIONAL)

Available only to groups with 20 or more eligible employees when Kaiser Permanente is the sole carrier. When selected, all HMO plans you offer will include this benefit and the cost will be factored in the medical plan rate.

☐ Add fertility benefit

8C DENTAL PLANS (OPTIONAL)

SUPPLEMENTAL FAMILY DENTAL PLANS

Supplemental Family Dental plans are available only when purchased with a medical plan and cover all enrolled members, including adults and dependent children up to age 26. These plans are not substitutes for the child dental coverage as required by the Affordable Care Act for members under 19 years old. A medical PPO plan member living outside California is not eligible for the DeltaCare HMO family dental plan. **Select only 1 dental plan.**

KPIC Fee-for-Service (Premier)	☐ Plan C	☐ Plan D	☐ Plan E	☐ Plan E with Ortho **(requires at least 10 subscribers)**	
KPIC PPO	☐ PPO AG 1500	☐ PPO AH 2000	☐ PPO D 1500	☐ PPO E 1000	☐ PPO E 1500
DeltaCare HMO	☐ 10A HMO	☐ 13B HMO			

Business name (please print): _____

9 IMPORTANT INFORMATION – PLEASE READ CAREFULLY

This is an application for coverage only. No contract for coverage will exist until Kaiser Foundation Health Plan, Inc. (KFHP), or Kaiser Permanente Insurance Company (KPIC) has completed its review and communicated to the business applicant or the applicant's broker that the application has been accepted and a group health plan contract/group policy will be issued.

The copay HMO plans, HSA-qualified high deductible health plans, deductible HMO plans, and the deductible HMO plans with HRA are underwritten by Kaiser Foundation Health Plan, Inc. (KFHP). Kaiser Permanente Insurance Company (KPIC), a subsidiary of KFHP, underwrites the Preferred Provider Organization (PPO) plans as well as the Premier and PPO dental plans. The chiropractic/acupuncture benefit is administered by American Specialty Health Plans of California, Inc.

10A AUTHORIZED AGENT/BROKER OF RECORD FOR KAISER PERMANENTE (TO BE COMPLETED BY BROKER, IF APPLICABLE)

If you're a broker who hasn't registered as a firm or agent with Kaiser Permanente, please call Broker Sales at **800-789-4661.** If any information has changed, please call Broker Compensation at **800-440-2323.**

Notice to agent or broker: If you've assisted the applicant in submitting this application, the law requires that you attest to this assistance. If, in making this attestation, you state as true any material fact you know to be false, you will be subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code section 1389.8(c) or Insurance Code section 10119.3, in addition to any other applicable penalties or remedies under current law.

I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation. **You must select *Yes* or *No.***

☐ Yes ☐ No

Primary (authorized agent/broker)

Agent/broker name	CA license #	% split

Firm name	Kaiser Permanente broker firm ID

Agent/broker signature **X**	Date

Secondary (only if adding another firm; doesn't apply to a second agent/broker at the same firm)

Agent/broker name	CA license #	% split

Firm name	Kaiser Permanente broker firm ID

10B GENERAL AGENT INFORMATION (TO BE COMPLETED BY BROKER, IF APPLICABLE)

General agency name	General agency ID

Email	Phone ( ) –

10C GENERAL AGENT ACCESS (TO BE COMPLETED BY EMPLOYER, IF APPLICABLE)

Your agent/broker may work with a General Agent (GA), an external partner, to service your account and they will have the same access to your group specific information to act on your behalf.

☐ Check this box if you do **not** authorize a GA to access your group specific information or to act on your behalf.

Business name (please print): _____

11 AGREEMENT AND SIGNATURE

Guaranteed Availability: Applications submitted between November 15th and December 15th with a January 1st effective date may be subject to Guaranteed Availability, which means that your company cannot be denied for not meeting the minimum participation and contribution requirements during this timeframe.

Domestic Partner Coverage: Coverage for state-registered domestic partners is included in all small group plans. You may also offer coverage to those who are not registered with this state. Kaiser Permanente is not advising on whether or not the law requires coverage of these individuals. Please seek guidance from your legal counsel on dependent coverage obligations.

As a company principal/corporate officer, having authority to contract with KFHP and KPIC, I agree that:

- My company is automatically enrolled in on-line billing and prepaid monthly premiums will be posted to Kaiser Permanente's account by the due date on the Kaiser Permanente billing statement. For any questions, please call **800-731-4661.**
- My company will use employee enrollment application forms provided or approved by KFHP and KPIC for new employees.
- My company's eligibility data provided to Kaiser Permanente will include coverage effective dates for employees that correctly account for eligibility in compliance with the waiting period requirement in the Affordable Care Act and federal regulations, which require that waiting periods not exceed 90 days. My company acknowledges that the effective date of coverage for new employees and their eligible dependents will be on the 1st of the month and won't exceed the waiting period established by my company.
- My company will abide by the contract provisions and maintain records of enrollment/wavier forms indefinitely, and upon request will produce documentation relating to a specific member to Kaiser Permanente at any time.
- My company may be subject to a recertification process to ensure my company meets all Kaiser Permanente requirements and those set forth in the California Health and Safety Code and the Affordable Care Act.
- Upon request, my company will furnish to KFHP or KPIC all data necessary to verify company and employee eligibility including, but not limited to, data proving compliance with the underwriting requirements and terms of the group agreement.

I have read, understood, and agreed to Kaiser Permanente's Small Business Guidelines, which is available at **kp.org/smallbusinessguidelines/ca** and may be included with my rate quote.

I attest that my company meets the definition of "small employer" as defined by applicable federal and state law.

I attest that my company isn't participating in a large group trust and agree not to participate while enrolled under Kaiser Permanente small business coverage.

I understand that if I have an authorized agent/broker of record and/or have authorized General Agent access, then those parties and their support staff currently on file with Kaiser Permanente will have access to my company-specific information. They're able to service my organization and to act or change company information on my behalf. Access to my account.kp.org group account will be granted to my agent/broker who may delegate authority to their support staff. This information may include, but isn't limited to, renewal notices, group agreements, rates, benefits, and protected health information (PHI).

I understand that a Summary of Benefits and Coverage (SBC) for each of my medical plans is available at **kp.org/smallbusiness-sbc/ca**. I agree to provide my eligible employees with SBCs for any plan(s) I have chosen or change to in the future.

I understand that if KFHP or KPIC intends to rescind or terminate my coverage, I'll be sent a notice via regular certified mail at least 30 days prior to the effective date of the rescission or termination explaining the reasons for the intended rescission or termination and notifying me of my right to appeal that decision to the Department of Managed Health Care director or the Department of Insurance commissioner. I understand that after 24 months following the issuance of my KFHP health plan contract/KPIC health insurance policy, KFHP/KPIC shall not rescind my plan contract/policy for any reason, and shall not cancel my plan contract/policy, limit any of the provisions of my plan contract/policy, or raise premiums on my plan contract/policy due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not.

I certify, to the best of my knowledge, that all of the responses given are true, correct, and complete. I understand that if I performed an act or practice constituting fraud or made an intentional misrepresentation of material fact, any coverage approved by KFHP or KPIC may be canceled or the applicable premiums/rates may be adjusted.

CALIFORNIA FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to a health plan or an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance benefits, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the state's regulatory agency. For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Notice: California law prohibits an HIV test from being required or used by health care service plans/health insurance companies as a condition of obtaining coverage/health insurance coverage.

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Business name (please print): _____

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Notice: Late Enrollment

Completed group eligibility and enrollment documentation received after the 1st of the requested effective month is considered late. Please note that there are potential group liabilities and impacts to your employees due to late enrollment. For more information, refer to the Underwriting Guidelines available at **account.kp.org/business/forms-and-documents**.

KAISER FOUNDATION HEALTH PLAN, INC., ARBITRATION AGREEMENT[1]

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage.*

Authorized company signer (please print name)	Company title (please print)
Signature (required) **X**	Date

[1]*Disputes arising from the following fully insured Kaiser Permanente Insurance Company coverages aren't subject to binding arbitration: 1) the Participating Provider tier and the Non-Participating Provider tier of the Point-of-Service (POS) plans; 2) Preferred Provider Organization (PPO) plans; 3) Out-of-Area Indemnity (OOA) plans; and 4) KPIC Dental plans.*